DWS-SDS
Form 61SS, 03/02

Utah' Job Connection

Date Received:

Utah Department of Workforce Services
APPLICATION FOR FINANCIAL, MEDICAL, FOOD STAMP, and CHILDCARE ASSISTANCE
Información en español describiendo como usted puede recibir estampas de alimentos más rápido (Expedited Food Stamps)

PLEASE PRINT

Last Name **First Name** **Middle Initial**	**Birth Date**	**Social Security Number**
Home Address (Include Street and City)		**Home Phone Number**
Mailing Address (Include Street and City)		**Work Phone Number**

Check The Box(es) in Front of Each Service You are Applying For:

☐ Financial and Supportive Services --- to support activities leading to increasing your family's income.
☐ Food Stamp Assistance -- gives the extra help you need to buy food.
☐ Medical Assistance -- provides health care services.
☐ Retroactive Medical Assistance -- pays for health care services received prior to date of application.
☐ Child Care Assistance -- provides some help in paying child care expenses.

Time & Date of Your Appointment: _____ PACMIS Number: _____
Person to be Seen: _____ Phone Number: _____
Comments / Referrals: _____

COMPLETING THIS APPLICATION CORRECTLY MAY AVOID POSSIBLE DELAYS:

1. **The amount of Financial, Medical, Child Care, or Food Stamp assistance you receive depends on the day you return this application to us.** You must answer all the questions on the application form, be interviewed, and verify any factors of eligibility (including income, assets, living arrangements, etc.) we may ask for, before benefits are issued (does not include expedited Food Stamp benefits). **The application effective date is the date the application is received and date stamped.**
2. Answer the questions as completely as possible. Please print. **If you need an interpreter, please tell us and we will make arrangements to help you.**
3. Do not write in the shaded areas of the form. These areas are for agency use only.
4. If you are applying for Food Stamp assistance ONLY, you do **not** need to answer the questions marked with an asterisk " * " . You must give us the Social Security Number (SSN) for all applicant household members. This is required under the Food Stamp Act of 1977 as amended by P.L. 97-98.
5. Your social security number will be used to check the identity of household members, to prevent duplicate participation and to facilitate mass changes. This may involve our contacting your employer, bank or other parties.
6. **If you need help with this application form, tell us. A DWS representative will be happy to help you.**

If you do not have time to complete this application and want to establish an effective date for benefits, complete page 1, sign page 2 and turn it in today. If you think you are eligible for Expedited Food Stamps follow the steps below.

TO APPLY FOR FOOD STAMP BENEFITS WITHIN 7 CALENDAR DAYS (EXPEDITED SERVICE):

1. Fill out this application.
2. If you do not have time to fill out all of this form today, complete pages 1 & 2 of the application, sign page 2 and turn it in TODAY. This will make sure your benefits start from today if you are eligible for Food Stamp benefits. Make an appointment for an interview before you leave the office.
3. You must complete the rest of the application form and give it to us within 7 calendar days. **If you cannot answer any of the questions now, you may answer them during an interview.** You must have an interview within 7 calendar days.
4. If you are eligible for expedited service, we will give you Food Stamp benefits for this month even if you cannot give us all the proofs we need. However, you must give us proof of identity.
5. **If you feel you are eligible for Food Stamp benefits within 7 days but your worker says that you are not, you may ask for a fair hearing. Then we must schedule an agency conference within two days.**

COMPLETE THIS SECTION IF YOU ARE APPLYING FOR FOOD STAMPS BENEFITS
YOU MAY BE ELIGIBLE TO RECEIVE FOOD STAMP BENEFITS WITHIN 7 CALENDAR DAYS!

We must take action on your Food Stamp application within 30 days from the day you apply. You may, however, be eligible for expedited service IF you are eligible for any Food Stamps.

Please answer these questions about your household. A Food Stamp household includes your spouse, parents, children, brothers and sisters and ALL other people who live and share food with you.

1. Does your household have LESS than $100 in cash, checking and savings accounts combined? ..... ☐ Yes ☐ No
2. Is your household's total gross income for this month (before deductions and taxes) LESS than $150? ..... ☐ Yes ☐ No
   (Include money received so far this month, AND money you will receive before the end of this month.)

Estimate your household's **total gross income** (income before taxes are taken out) for the month .....$

3. Is the total of your cash, bank accounts and income for this month
   less than your total shelter cost (rent or mortgage plus utilities)? ..... ☐ Yes ☐ No
4. Are you a migrant or seasonal farm worker? ..... ☐ Yes ☐ No
   a. If so, will you receive income later this month? ..... ☐ Yes ☐ No
      (Include only income you are sure you will receive before the end of the month.)
   b. How much? $_____ When?_____
5. When did you last receive Food Stamp benefits? _____ Where?_____
6. Are you a boarder? ..... ☐ Yes ☐ No
   Boarders are individuals who live with others and make payment for lodging and meals.
7. Have you received or are you receiving tribal commodities ? .....☐ Yes ☐ No

Your Signature:_____ ***Date:***_____

Office Use Only: Expedited Food Stamps ☐ Yes ☐ No Reason: _____ Housing:_____
Screened by: _____ Date: _____ SUA:_____
Total:_____

• Equal Opportunity Employer/Program. Auxiliary aids and services are available upon request to individuals with disabilities by calling (801) 526-9240. Persons with speech or hearing impairments may call the State Relay at 1-800-346-4128.

In accordance with Federal law and the U.S. Department of Agriculture (USDA) and the U. S. Department of Health and Human Services (HHS) policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. Under the Food Stamp Act and USDA policy, discrimination is prohibited also on the basis of religion or political beliefs.

ATTENTION

If you are not registered to vote where you live now, would you like to apply to register to vote here today? ☐ Yes ☐ No
If you do not check either of these boxes, you will be considered to have decided not to register to vote at this time.
If you would like help in filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private. Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency. If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with: Lt. Governor, State of Utah, 203 State Capitol Building, Salt Lake City, UT, 84114

When your family applies for benefits, you must tell us about the citizenship and immigration status of everyone in your family. Each person in your family must give us his or her social security number. If they don't have one, they must get one. We can help. If anyone in your household does not want to give us information about his or her citizenship, immigration status or social security number, that person can be designated a non-applicant. This means that person will not be considered an applicant and will not be eligible for benefits. That person will still need to answer other questions about his or her name, relationship, income, resources, etc.. as that information may affect the eligibility of the applicant. The Department of Workforce Services will not contact INS regarding the immigration status of non-applicant household members who are not required to provide their immigration status, citizenship or social security number.

List all the people who live in your home. Start with yourself.
For those individuals not asking for assistance, list only their name and relationship.

	Last Name, First Name, Middle Initial	How Related	Social Security No. ---------- Medicare Number	Birth Date	Age	Sex	Marital Status	Citizen Y/N	Training/ School	
1	Race_____	**Self**							Grade Completed?	
									Currently Attending? Where?	Yes No
2	Race_____								Grade Completed?	
									Currently Attending? Where?	Yes No
3	Race_____								Grade Completed?	
									Currently Attending? Where?	Yes No
4	Race_____								Grade Completed?	
									Currently Attending? Where?	Yes No
5	Race_____								Grade Completed?	
									Currently Attending? Where?	Yes No
6	Race_____								Grade Completed?	
									Currently Attending? Where?	Yes No
7	Race_____								Grade Completed?	
									Currently Attending? Where?	Yes No
8	Race_____								Grade Completed?	
									Currently Attending? Where?	Yes No

1. What is the primary language spoken in the household?_____

2. Is anyone in your home a boarder? ..... ☐ Yes ☐ No
Boarders are individuals who live with others and make payment for lodging and meals.

*3. Is anyone in your home pregnant? (Medical proof of pregnancy will be required.) ..... ☐ Yes ☐ No

Name:	Expected Date of Birth:

4. Do you buy, store or prepare food with everyone in your home? (If no, list below anyone who doesn't) ..... ☐ Yes ☐ No

Name(s):

5. Is anyone 16 or older unable to work because of physical or mental problems? ..... ☐ Yes ☐ No

Name:	Date unable to work:	When able to work?
Medical Problem (a medical verification may be required):		

*6. Do you want help with bills for medical care that anyone in your home received in the last 3 months? ..... ☐ Yes ☐ No

Name:	Date of Service:

*7. Do you have a legal guardian or someone who has power of attorney for you? ..... ☐ Yes ☐ No

Name:	Address:	Telephone:

8. Do you need an authorized representative to help you use your Financial, Medical and Food Stamp benefits and/or receive copies of your notices? If yes, list the name and address of the representative(s). ..... ☐ Yes ☐ No

Name:	Address: (include city, state and zip code)	Telephone:

9. Is anyone in your household living in one of these institutions? ..... ☐ Yes ☐ No

☐ Hospital ☐ Shelter ☐ Drug/Rehab Center ☐ Boarding School
☐ Group Home ☐ Nursing Home ☐ Jail - If yes, on work release? Yes / No

Name:	Name of Institution:	Admission Date:	Release Date:

*10. Has anyone in your home who once received SSI later stopped receiving SSI? ..... ☐ Yes ☐ No

Name:	Date Stopped Receiving SSI:

*11. Is anyone in your family, living or deceased, a veteran of the U.S. Armed Forces? ..... ☐ Yes ☐ No

Name:	Relationship:

12. Is anyone in your home known by another name, such as a maiden name or former married name? ..... ☐ Yes ☐ No

Current Name:	Other Last Name:	First Name:

13. Has anyone in your home ever applied for/received financial or medical assistance or Food Stamp benefits? ..... ☐ Yes ☐ No

Name:	Where?	Type of Assistance:	When?

*14. Do you intend to make your home in Utah? ..... ☐ Yes ☐ No

15. A. Are you a fleeing felon? . . . . ☐ Yes ☐ No B. Are you violating your probation or parole? ..... ☐ Yes ☐ No

16. Are you or any household member now disqualified from the Food Stamp or a Financial program for providing incorrect information? ..... ☐ Yes ☐ No

If yes, which household member?_____ In what state?_____

17. Are you interested in receiving information about assistance available to parents who wish to legally give up custody of a child for adoption? ..... ☐ Yes ☐ No

18. **Please answer these questions if any applicant in your home is NOT a U.S. citizen.**
Emergency Medical Services will NOT be denied due to citizenship status.

Name:	Alien #:	Entry Date:	Country of Origin	Sponsor or Resettlement Agency	REFI
Status: ☐ Refugee ☐ Permanent Resident ☐ Temporary Resident with Amnesty ☐ Other					
Name:	Alien #:	Entry Date:	Country of Origin	Sponsor or Resettlement Agency	REFI
Status: ☐ Refugee ☐ Permanent Resident ☐ Temporary Resident with Amnesty ☐ Other					

19. Has anyone in your household changed jobs or stopped working in the last 2 months? ..... ☐ Yes ☐ No

Name	Name of Employer : Phone Number:	Date Left Job	VOQS
Date Last Check Received:	Reason for Leaving:	Is it a Temporary Layoff? Date Expected to Return to Work:	
Name	Name of Employer : Phone Number:	Date Left Job	VOQS
Date Last Check Received:	Reason for Leaving:	Is it a Temporary Layoff? Date Expected to Return to Work:	

20. A. Has anyone refused a job or reduced work hours in the last 60 days? ..... ☐ Yes ☐ No

Name Reason for Refusal/Reduction VOQS

B. Is anyone on strike? ..... ☐ Yes ☐ No

Name Date Strike Began Employer VOQS

21. Has anyone sold, traded, transferred or given away vehicles, property, money, or other assets in the last 36 months (for Food Stamps, in the last three months)? (Please list the items and explain.) ..... ☐ Yes ☐ No

_____

*22. If you are applying for Financial or Medical Assistance, do you have any one personal household item that could be sold for $500 or more? (Please list the item and explain)..... ☐ Yes ☐ No

_____

23. Does anyone (including children) have any of the items listed below? ..... ☐ Yes ☐ No
Does anyone have their name on an account belonging to someone else? ..... ☐ Yes ☐ No

☐ **Sa**V**i**ngs Account ☐ **P**ersonal **C**hecking Account ☐ **T**rust **F**und (TF/TM/TR) ☐ **IR**A/KEOGH/401K
☐ **C**redit **U**nion Account ☐ **M**oney **M**arket Certificates ☐ **CA**sh ☐ **II**M Account (Tribal oil/gas monies)
☐ **T**ime **C**ertificates ☐ **St**ocks/Bonds ☐ Other

Name of Financial Institution	Account Number	Joint? Yes/No	Type of Account	Owner/Joint Owners	Amount	Ver	FIAC

24. Does anyone own or is anyone buying any of the types of vehicles listed below, or does anyone have their name on a vehicle belonging to someone else? ☐ Yes ☐ No

☐ **CAr** ☐ **S**now**M**obile ☐ **M**otor**C**ycle ☐ **O**ther **V**ehicle (dune buggy, ATV, etc.)
☐ **T**ruc**K**/Van ☐ **M**otor **H**ome ☐ **B**oa**T**s/Motors

Type of Vehicle	Make	Year/ Model	Licensed Yes/No?	State and License #	Owner/Joint Owners	Use	Amount Owed	Current Value	Ver	VEHI

25. Does anyone own, or is anyone buying, any of the types of property listed below? Include property co-owned with someone not living with you. ☐ Yes ☐ No

☐ **Ho**me You Live In (Exempt) ☐ **C**amper/**T**railer ☐ **L**i**F**e Insurance (**LF**/**LI**)
☐ **O**ther **H**omes ☐ Notes or Contracts (**NC**/**NO**) ☐ **F**uneral **P**lan/Burial Contract
☐ **T**ime **S**hare Condos ☐ Burial Plans/Cemetery Plots (**BS**/**BC**) ☐ Oil or Gas Leases
☐ Rental Property ☐ **L**ivestock/Horses (**LC**/**LX**) ☐ **L**ife **E**states/Life Leases
☐ Land/**M**ineral **R**ights ☐ **T**ools/**E**quipment/Inventory ☐ Other

Type of Property	Owner/Joint Owners	Joint? Y/N	Face/Market Value	Equity/Cash Value	Ver	OTAS

26. Has any applicant household member filed for bankruptcy? ☐ Yes ☐ No If yes, when?_____

27. Has anyone in your home applied for or received educational benefits? ☐ Yes ☐ No

☐ Scholarships **(BI/OF/ON)** ☐ **V**.A. **E**ducational Benefits
☐ Other Educational Grants and Loans **(OD/OE/OF/ON)** ☐ **PE**LL/BEOG ☐ **SE**OG
☐ Other (include family, work study, church, employer, etc.) ☐ SSIG **(ST)** ☐ **ND**SL

School Name: _____	School Name: _____	UNIE
Amount of Benefits: _____	Amount of Benefits: _____	
Time Periods Covered: _____	Time Periods Covered: _____	
Educational Expenses: _____ (tuition, books, fees)	Educational Expenses: _____ (tuition, books, fees)	
Expected Graduation Date: _____	Expected Graduation Date: _____	
Circle one: Full-time ½ time Less than ½ time	Circle one: Full-time ½ time Less than ½ time	

28. Has anyone applied for or received any of these types of UNEARNED INCOME? ☐ Yes ☐ No

☐ **S**ocial **S**ecurity ☐ Unemployment Insurance (**UC**) ☐ Civil Service Annuity
☐ Church Assistance (**CC**/**IK**) ☐ **R**ailroad **R**etirement ☐ Tribal Funds (**OC**)
☐ S**SI** ☐ **W**orker's **C**ompensation ☐ Cash Gifts (**CC**)
☐ **C**hild **S**upport ☐ **V**eter**A**n's Benefits ☐ Pension (**CV**/**RT**)
☐ **AL**imony ☐ **L**ump **S**um Payments ☐ Other

Are any deductions being withheld from these benefits (child support, taxes, health insurance, overpayments, etc.)? ☐ Yes ☐ No
If yes, explain

Name	Type of Unearned Income/Claim Number	Denied Yes/No	Amount	How Often	Date Applied/ Received	Date Benefits Will Begin	UNIN
			$	per			
			$	per			
			$	per			

29. A. Employment information - **YOU WILL BE ASKED TO VERIFY THIS INCOME.**

NAME			NAME		
Is this a temporary job?	If yes, how long will it last?	What is your hourly wage?	Is this a temporary job?	If yes, how long will it last?	What is your hourly wage?
How often paid? (circle one): 2X monthly Every 2 weeks Monthly Weekly Daily Hourly Other			How often paid? (Circle one): 2X monthly Every 2 weeks Monthly Weekly Daily Hourly Other		
Name of Employer (Employer may be contacted) Address and Phone Number			Name of Employer (Employer may be contacted) Address and Phone Number		
Date Started	Average Hours Worked per Week	Day of Month/Wk Paid	Date Started	Average Hours Worked per Week	Day of Month/Wk Paid

Date Paid Day/Mo/Yr	Hours Worked	Gross	Tips	Actual/ Best Est.	Date Paid Day/Mo/Yr	Hours Worked	Gross	Tips	Actual/ Best Est.

B. Are any deductions being withheld from these benefits (child support, garnishments/withholding, health insurance, overpayments, taxes, etc.)? ..... ☐ Yes ☐ No
If yes, explain

30. Is anyone in the household SELF - EMPLOYED? ☐ Yes ☐ No

If yes, list the Annual Income: $_____ Annual Expenses: $_____
(You will be required to verify the income and expenses.)

31. A. Does your employer offer health insurance coverage for you? ☐ Yes ☐ No If yes, what is your cost per month? $_____
B. Does your employer offer health insurance coverage for your dependents? ☐ Yes ☐ No Cost per month? $_____
If yes, when is open enrollment?
If yes and *not* covered, why not? (check one) 9 Cost of coverage too high 9 Does not cover children's health needs
9 Limited Benefits 9 Other:

32. Do you expect any CHANGES in your circumstances ? ..... ☐ Yes ☐ No
If yes, check those that apply and explain_____

9 Earnings 9 Dependent care 9 Income 9 Number of Hours Worked
9 Resources 9 Expenses 9 Living Arrangements 9 Other _____

33. If you are applying for Child Care, please complete for all adults who attend training or education.

First Adult — # of hours per week: Expected completion date:

Second Adult — # of hours per week: Expected completion date:

34. Do you pay for dependent care so you can go to work, look for work, or get training? ..... ☐ Yes ☐ No

Name of Dependent	Amount Paid Each Month (Attach Receipts)	Who Pays the Expense?	Name of Dependent	Amount Paid Each Month (Attach Receipts)	Who Pays the Expense?

35. Do you pay any Child Care expense in addition to the State supplement? ☐ Yes ☐ No
If yes, how much per month?_____ (You will need to provide verification/receipts from the provider.)

36. Are you legally obligated to pay child support to a non-household member? ..... ☐ Yes ☐ No
If you are paying, how much? $_____ **(If yes, provide receipt)**
* If yes, are you a spouse or parent of a disabled person? ..... ☐ Yes ☐ No

FOOD STAMP PROGRAM EMPLOYMENT RULES

37._____ is the head of household. Circumstances may change who you have designated as head of household. If the **head of household quits a job without a good reason**, the entire household may be disqualified from the Food Stamp Program. The purpose of the Food Stamp Employment and Training Program is to help people get jobs by providing job assistance. Workshops are provided on how to get a job. Anyone may volunteer.

Household members **not** exempt:

38. If you are applying for Food Stamps, do you have a heating or cooling expense separate from your rent or mortgage costs? ..... ☐ Yes ☐ No
A. How is your home heated? (gas, electric, etc.)
B. How is your home cooled?
C. I received HEAT/LIHEAP assistance at my current residence in the last year? ..... ☐ Yes ☐ No

39. **UTILITIES: CHECK THE ONE THAT APPLIES TO YOUR HOUSEHOLD: You may need to verify actual utility expenses.**

☐ **1. STANDARD UTILITY ALLOWANCE**
You are allowed the Standard Utility Allowance for your utility costs if you have a heating or cooling cost that is separate from your rent or mortgage. You must show that you pay the heating or cooling utility.

☐ **2. WITHOUT HEATING/COOLING ALLOWANCE**
You are allowed the Without Heating/Cooling Allowance for your utility costs if you pay utility costs other than heating or cooling. You must show that you pay those utility costs.

☐ **3. TELEPHONE ONLY ALLOWANCE**
You are allowed the Telephone Only Allowance ($20 limit) for your utility costs if your only cost is for telephone service.

Do you pay for the utility costs at a home that you do not currently live in? ..... ☐ Yes ☐ No

40. Do you share any of these shelter or utility costs with any people that you live with? ..... ☐ Yes ☐ No
If yes, how is it shared?

41. Do you receive housing assistance, including cash assistance or vouchers, etc.? ..... ☐ Yes ☐ No
If yes, how much per month? $

42. Check the boxes in front of each expense you pay below. These are expenses for which you are billed. Check the boxes even if you receive HEAT assistance. List the amounts your household is billed for each of the items you checked

Expense	Current Amount	Past Due Amount	How Often Billed?	Who is Responsible For Payment?	Who Pays the Bill?	Ver	SHEX
☐ Rent							
☐ Mortgage							
☐ Second Mortgage							
☐ Trailer Space Lot Payment							
☐ Homeless Shelter Costs							
☐ Property Taxes (If **NOT** included in mortgage)							
☐ Insurance on Home (If **NOT** included in mortgage)							

43. Is your rent Government-subsidized? ..... ☐ Yes ☐ No
If yes, what is the amount YOU pay? $_____ Agency's Name _____

44. If you are applying for medical assistance, do you have an impairment-related work expense? ..... ☐ Yes ☐ No
If yes, please explain:

*45. Do you have anyone who can help you pay for medical bills; such as a spouse, parents, adult children, or insurance (car insurance, home owners insurance, health insurance, etc.)? ..... ☐ Yes ☐ No

Provide insurance information and/or name, address of family member or friend helping you.

Insurance Company	Amount Paid (HA) $ _____ NEXT Payment Due:_____ per (pay period, month, quarter, semi-annual, year)	**E X P E**
Name and address of friend or family member:		

46. A. Does any person or organization give you money to pay expenses? ..... ☐ Yes ☐ No
B. Does any person or organization pay any expenses for you? ..... ☐ Yes ☐ No

Name of Person/Organization	Amount	Type of Expense

47. A. Is anyone court ordered to pay medical insurance for your children? ..... ☐ Yes ☐ No
If yes, for which child(ren):_____(verify insurance)

B. Could your children's health insurance coverage be provided by another parent or another person? ☐ Yes ☐ No

48. Have you paid any medical bills in the last 3 months or do you have any unpaid bills such as:
(You will be asked to provide verification of these bills.)

☐ Medical, Dental Expenses ☐ Hospital or Nursing Care ☐ Dentures, Hearing Aids, Eyeglasses
☐ Transportation for Medical ☐ Medicare Premium/Insurance ☐ Medication (required by doctor)
☐ Other (explain)

For the Food Stamp Program, ONLY elderly/disabled household members are allowed a deduction for medical expenses.

AVOID PROBLEMS!

You can avoid problems by making sure you know your rights and responsibilities and the rules for public assistance. Please read the statements below carefully. If you do not understand something, ask a DWS representative about it. Make sure you understand everything before you sign this application form.

- Under penalty of perjury, I certify that all applicant household members are U.S. citizens or aliens in lawful immigration status, unless otherwise specified.
- I have received a brochure called "Rights and Responsibilities." I will read this brochure. If I do not understand anything in the brochure, I will ask a DWS representative to explain it to me.
- **All the members of my household will obey Food Stamp (if applying for Food Stamps) and Financial Assistance (if applying for Financial) Program rules. We will not lie or hide information. We will not give Food Stamps to anyone who has no right to use them. We will not use Food Stamps to buy ineligible items. We will not use anyone else's Food Stamps unless we are their authorized representative. If we break any of these rules, we may not be allowed to have Food Stamps or Financial Assistance. The first time, we may not be allowed to have these benefits for 12 months. The second time, 24 months and the third time, we may be permanently disqualified from the Food Stamp or Financial Program. We may also be fined up to $250,000 or put in jail up to 20 years. We may also be prosecuted under other laws. A court can also order an individual off the program for an additional 18 months. If I use Food Stamps to buy or sell controlled substances (illegal drugs or certain drugs for which a doctor's prescription is required) I can be disqualified from the Food Stamp Program, 24 months for the 1st offense and permanently for the second offense. If I use Food Stamps to buy or sell firearms, ammunition, or explosives I can be disqualified from the Food Stamp Program permanently. An individual will be permanently disqualified if convicted of trafficking Food Stamp benefits of $500 or more. An individual will be disqualified for 10 years if the person makes fraudulent statements about identity and residence to get multiple benefits.**
- Failure to report or verify any of the above listed expenses will be seen as a statement by your household that you do not want to receive a deduction for the unreported expense.

- In consideration of Medical Assistance, I assign to the Utah Department of Health all my rights to medical benefits. I authorize payment of the benefits directly to the Department of Health. If the Utah Department of Health pays for my medical care, I will give them any money I collect from an insurance policy. I will also give them any money I collect from someone liable for my medical expenses. I agree to hold harmless any person or organization making payment to the Department of Health because of this agreement. I authorize any person or organization to release medical records or information about my health or the health of my dependents to the Department of Health, Division of Health Care Financing or designee. The Department of Health and the Department of Workforce Services may release information about my medical eligibility status to health care providers.

- I agree to cooperate with the State of Utah to establish and collect alimony and child support for my family.

- In consideration of being accepted under the Utah Medicaid program, the Utah Medical Assistance Program, and C.H.I.P., I agree the assistance I receive under either program is limited to that described in the Provider Manuals. These manuals have been established for each program and may be further limited by applicable state and federal law. I further agree the Department of Health may amend the manuals and benefits for which I am eligible without my consent and without additional consideration for me. The Department of Health shall make manuals available for my review at their main offices.

- I understand financial assistance for most families is time-limited to a total of 36 months, beginning January 1, 1997. Additional months may be approved if I have a history of working part-time (80 hrs/month) while receiving financial assistance or if I have been certified as medically unable to work. The 36 month time limit does not apply when all parents in a household receive SSI assistance or when assistance is being provided to children living with a relative who is not included in the financial assistance.

- I understand as a condition of applying for financial assistance I have automatically transferred to the Office of Recovery Services, all monies payable to me or my child(ren) for any person as support, alimony or medical support from the date of application. The monies include the amount past due or to become due to me or my child(ren). If my application is denied, my rights to support, alimony, or medical support will revert back to me. I further understand that anyone may deliver to the Office of Recovery Services all drafts, checks, money orders or other negotiable instruments due by any person obligated to provide support. The Office of Recovery Services has the power of attorney to act in my name endorsing and cashing all drafts, checks, money orders or other negotiable instruments received by the Department as support payments.

- Upon approval of General Assistance, I give any and all my rights to other financial benefits to the Department of Workforce Services. I understand General Assistance is time-limited to 24 months in a 60 month period with no extensions.

- I may be contacted by Quality Control to review the eligibility on my assistance. I agree to cooperate with this review.

- I am responsible to reimburse the state for child care services which were paid for by the state, but I was not eligible to use. I understand if I choose a license-exempt child care provider, the state of Utah does not regulate or monitor the child care.

49. I (please print name), _____, read or had read to me the statements above. I understand those statements. Under penalty of perjury, I swear that the answers I have given on this application are true and correct. I am the person represented by the signature on this document. I understand that any false information on this application will result in prosecution for fraud. **I understand that I may request a fair hearing orally or in writing if I disagree with the decision made on this application.** I understand that DWS may contact me, or have someone contact me, about the effectiveness of services I received.

Your Social Security Number, as well as other information you give us, will be subject to verification by Federal, State and Local officials. Using the State Income and Eligibility Verification system, we will make sure your household is eligible for Food Stamps and other Federal assistance programs through electronic matches. Computer matching, program reviews, and audits will be done with Immigration and Naturalization Service, Social Security, and Internal Revenue Service records. Eligibility determination includes inquiries to banking and loan institutions and any other organizations or individuals who may have eligibility information about you and other household members. Computer checks will be done when you apply and after you receive assistance. Your benefits of Food Stamps, financial, Child Care, and Medicaid may be reduced, denied, or terminated because of information from these sources. Knowingly providing false information may result in criminal or civil action and/or administrative claims.

_____ _____

Signature or Mark of Customer **Date**

_____ _____

Signature or Mark of Spouse **Signature of Authorized Representative (FS only)**

Birth Date of Auth. Rep. _____